

## Patient Information

Name: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip Code: \_\_\_\_\_

Telephone: (Home): \_\_\_\_\_ Telephone: (Work or Pager): \_\_\_\_\_

Telephone: (Fax): \_\_\_\_\_ e-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F (circle one) Marital Status: M W D S (circle one)

Employer: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Who referred you? \_\_\_\_\_

Person to contact in emergency: \_\_\_\_\_ Emergency telephone: \_\_\_\_\_

Special needs: \_\_\_\_\_

### Responsible Party

Party Responsible for Payment: Self Spouse Parent Other

Name (if other than self): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Primary Insurance

Primary Medical Insurance: \_\_\_\_\_

Insured Party: Self Spouse Parent Other

Insured Name (if other than self): \_\_\_\_\_

Insured ID#: \_\_\_\_\_ Group/Plan No.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Secondary Insurance

Secondary Medical Insurance: \_\_\_\_\_

Insured Party: Self Spouse Parent Other

Insured Name (if other than self): \_\_\_\_\_

Insured ID#: \_\_\_\_\_ Group/Plan No.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Office Policy:** All incurred charges are due and payable at the time of service. I understand that I am financially responsible to the dietitian for the charges incurred by myself and/or my dependents. Please note that Medicare will not reimburse either the dietitian or the patient for services rendered by this office. Insurance information is being requested only to facilitate correspondence should it become necessary.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Name: \_\_\_\_\_

1. Reason(s) for visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Do you have any medical condition(s)?  Yes  No

Type	Time of Onset

3. Do you have any food allergies or aversions?  Yes  No If yes, please list:  
\_\_\_\_\_  
\_\_\_\_\_

4. Do you take any prescription medications?  Yes  No

Name	Dose	Time of Day	Reason For Taking

5. Do you take over-the-counter medications or vitamins?  Yes  No

Name	Dose	Time of Day	Reason For Taking

Name: \_\_\_\_\_

6. What do you drink?

Type	Amount per Day
Water	
Milk	
Alcohol	
Caffeinated soft drinks, coffee, or tea	
Decaffeinated soft drinks, coffee, or tea	

7. Do you smoke?  Yes  No Amount: \_\_\_\_\_

8. Do you salt your food?  Freely  Sparingly  Not at All.

9. Do you exercise?  Yes  No

Type(s)	Frequency	Duration

10. Have you ever followed a special diet?  Yes  No

Type	Date	Success more than 1 year?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

11. **If you are pregnant:** Due Date: \_\_\_\_\_ Prepregnancy Weight: \_\_\_\_\_

Number of Previous: Pregnancies: \_\_\_\_\_ Children: \_\_\_\_\_

Will you be breastfeeding?  Yes  No How long? \_\_\_\_\_

12. **If you have diabetes:** Type: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Do you test your blood sugar?  Yes  No How many times per day? \_\_\_\_\_

Type of meter used: \_\_\_\_\_ Usual readings: \_\_\_\_\_

Do you have any complications?  Yes  No If yes, please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



**Mary Alice Volkert & Associates**  
6565 West Loop South, Suite 510  
Bellaire, TX 77401-4111  
Phone (713) 668-2759 Fax (713) 668-2762

\_\_\_\_\_, MD  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dear Dr. \_\_\_\_\_,

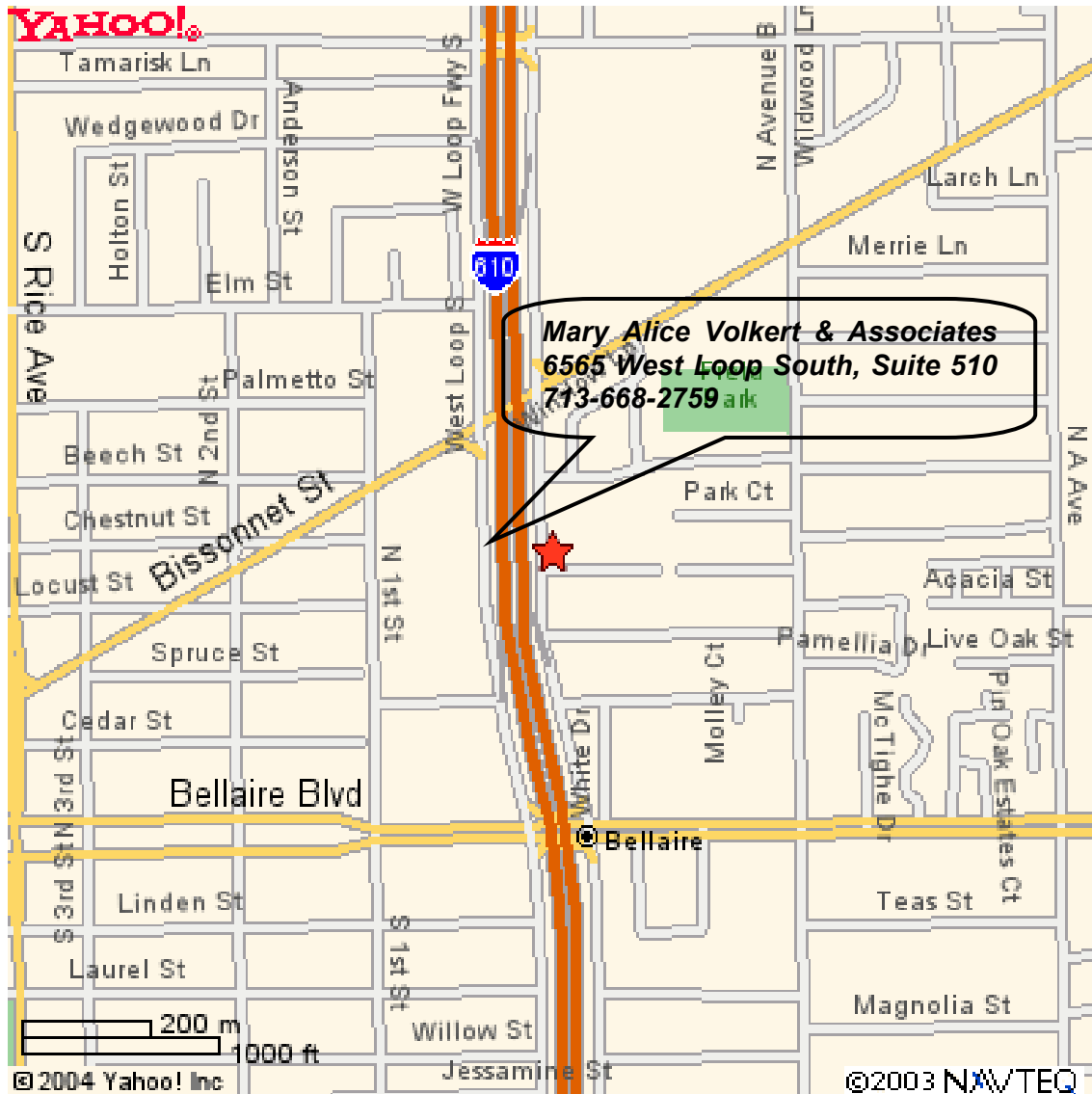
I, \_\_\_\_\_, hereby release any medical records or laboratory work to **Mary Alice Volkert, MS, RD, LD**, for my appointment.

Sincerely,

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**Mary Alice Volkert & Associates**  
6565 West Loop South, Suite 510  
Bellaire, Texas 77401  
Phone (713) 668-2759 Fax (713) 668-2762



The office is located at **6565 West Loop South, Suite 510, in Bellaire**. Take the “**Bellaire**” exit (**going either direction**) and head north on the feeder towards **Bissonnet**. Our location is the north building of a pair of 8-story black glass “boxes” on the Loop 610 northbound feeder road. Visitor parking is free and plentiful around the buildings, and there is more free covered parking in the garage behind the buildings. An elevator is available on the south end of the garage.

We look forward to seeing you soon!